Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to authorize Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. and/or Blue Cross Complete of Michigan to disclose your protected health information to an individual other than yourself. If you are completing this form for yourself, please fill out Sections A through E. If you are filling out this form on behalf of someone else, please complete Sections A through D and Section F.

**Section A: Authorization –** I authorize the use and disclosure of my protected health information as described in Sections B and C. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

| NAME | | DAYTIME PHONE NUMBER | |
|---|---|---|---|
| ADDRESS | | | |
| CITY | STATE | ZIP | ENROLLEE ID |

☐ Check here if you are a Blue Cross Blue Shield of Michigan member
☐ Check here if you are a Blue Care Network member
☐ Check here if you are a Blue Cross Complete of Michigan member

**Section B: Description of protected health information to be disclosed –** Describe in detail the protected health information to be used and disclosed (you can state "any and all" or provide specific information such as the providers, dates of treatment or type of service that you would like to disclose):

Please check if your authorization will include the disclosure of the following types of protected health information:

☐ **Substance abuse** (including alcoholism)
☐ **AIDS, AIDS-related complex, or HIV**
☐ **Mental health services** (excluding psychotherapy notes – use form 7656 to authorize the disclosure of psychotherapy notes)

**Section C: Authorized recipient of the protected health information –** State who you are authorizing to receive protected health information. *If protected health information is disclosed under your authorization to persons or organizations that are not subject to federal or state privacy laws, it may* be re-disclosed and no longer protected.

☐ I authorize you to disclose my protected health information to the following person(s) and entities:

The purpose(s) of this disclosure is (you may state "at my request"): _____

☐ I authorize the following person or entity to disclose my PHI to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. and/or Blue Cross Complete of Michigan:

The purpose(s) of this disclosure is (you may state "at my request"): _____

**Section D: Expiration and revocation**

This authorization will expire on: _____ OR when the following occurs: _____
*Date*

I understand that I can revoke this authorization at any time by submitting a written request on a standard form, available online or by calling 313-225-9000. I understand that revocation will not affect actions taken prior to our receipt of any revocation request.

**Section E: Signature**

_____ _____
*Signature* *Date*

**Section F: Personal representative –** If you are not the patient, please sign and date section F of this form. Check the box that describes your relationship to the member. **If you are not the parent, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc).**

Printed name of personal representative: _____

Signature of personal representative: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

**INSTRUCTIONS FOR COMPLETING**
**THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Fill out the form completely**. The authorization is not valid unless it is filled out completely.

- This form cannot be used as a joint authorization with another member; therefore, each member must submit a separate form
- Please type or print the information

**Section A: Authorization.** Please include the following information about the member whose protected health information is being disclosed:

1) Member's first and last name.
2) Member's full street address, including city, state and ZIP code.
3) Include the member's enrollee ID/contract number as it appears on the member's Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care of Michigan, Inc., Blue Care Network Service Company, or Blue Cross Complete of Michigan ID card.
4) Member's telephone number, including area code.
5) Check the appropriate box for your health care coverage provider. For Blue Care Network Service Company and Blue Care of Michigan, please select the box designated "Blue Care Network member."

**Section B: Description of protected health information to be disclosed**

1) List the information to be used and disclosed (for example you can put "any and all" or list the specific claims or dates covered by the authorization).
2) Check the appropriate box if you wish to disclose the following types of protected health information:
   a. Substance abuse (including alcoholism)
   b. AIDS, ARC, HIV
   c. Protected health information related to mental health services

**Section C: Authorized recipient of the protected health information**

1) If you want us to disclose protected health information, check the first box and list the person or entity to whom the protected health information will be disclosed. Include first and last name when you want to authorize a specific individual to receive your protected health information.
2) Please describe the purpose for the disclosure. You may simply state "at my request" if appropriate.
3) If you are authorizing another person or entity (such as a hospital or doctor) to release protected health information to us, please check the second box and list the person or entity who you are authorizing to provide protected health information to us.
4) Once again describe the purpose for the disclosure. You may simply state "at my request" if appropriate.

**Section D: Expiration and revocation**

1) Fill in the date when the authorization will expire (day, month and year) or the event or activity that will trigger expiration of the authorization (e.g. until revoked or upon my death).
2) Members can revoke authorizations at any time. Revocations must be submitted using the standard BCBSM revocation form. Members can get the forms online at **bcbsm.com** or by calling 313-225-9000.

**Section E: Signature** – **Members must sign and date the authorization** unless the form is completed by their personal representative (see below).

**Section F: Personal representative**

1) If a personal representative is signing the authorization form on behalf of a member, the representative must sign his or her name and date in the signature line and specify his or her relationship to the member by checking the appropriate box below the signature.
2) The personal representative must print his or her name, relationship to the member and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof is required.

**The signer will receive a copy of the completed authorization form via return mail. The original authorization form will be kept on file.**

| Mailing instructions | Faxing instructions |
|---|---|
| Please mail completed authorizations to:<br>BCBSM<br>Mail Code **X420**<br>600 E. Lafayette Blvd.<br>Detroit, MI 48226 | Please fax completed authorizations to:<br>**1-866-894-3101**. |

Members who need additional assistance completing this form should call a customer service representative at the number listed on the back of their Blues ID card, or the Blues operator at 313-225-9000.